

5046
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown, X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Alice Middle Angell Last Angell		4. DATE OF DEATH Month May Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1864
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Taneytown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Baumgardner		14. MOTHER'S MAIDEN NAME Sarah Dutterer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Rena Hitchcock		Address Taneytown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 9 years			INTERVAL BETWEEN ONSET AND DEATH 36 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-18 , 19 41 , to 5-15 , 19 57 , that I last saw the deceased alive on 5-14 , 19 57 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald E. Piper		ADDRESS (Street, city or town, state) 49 Frederick St. Taneytown, Md.	
PHYSICIAN'S NAME (Type) Donald E. Piper		DATE SIGNED 5-15-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/18/1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery	22d. LOCATION (City, town, or county) (State) Taneytown, Carroll Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. L. Allison		ADDRESS Emmitsburg, Md.	24a. REC'D BY REGISTRAR DATE MAY 20 '57
		24b. REGISTRAR'S SIGNATURE Overland	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

NO 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05030

5047

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mos.12days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 15X2-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Mae Ricketts ANGELL		4. DATE OF DEATH Month Day Year May 14, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 Feb. 22, 1885
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 2 Days 22 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Ricketts Hanson Ricketts		14. MOTHER'S MAIDEN NAME Martha Carlisle Martha Carlisle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) C.B.S. associated with cerebral arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 334X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 2, 1957 to May 14, 1957 , that I last saw the deceased alive on May 14, 1957 , and that death occurred at 7:30A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 5/14/57			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/57	22c. NAME OF CEMETERY OR CREMATORY Darnestown Presby.	22d. LOCATION (City, town, or county) (State) Darnestown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 5/17/57		24b. REGISTRAR'S SIGNATURE C. Harry Myers	

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

1957

1957

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BUREAU V. B.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05031
83

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT AIRY</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RIDGEBVILLE - JACKSON'S HOME</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3801.4</u> ✓ d. STREET ADDRESS <u>2405 FAIRMOUNT AV.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRONISLAW BALCEROWICZ</u> 4. DATE OF DEATH Month Day Year <u>May 31 1957</u>				5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1887</u> 9. AGE (In years last birthday) <u>70</u> yrs. 10. UNDER 1 YEAR Months Days Hours Min. 11. UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINETMAKER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME _____ 14. MOTHER'S MAIDEN NAME _____			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Mrs Bannach</u> Address <u>2405 Fairmount Ave</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>5/31/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 3/57 Holy Rosary</u> 22b. DATE THEREOF <u>June 3/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u> 22d. LOCATION (City, town, or county) (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozajewski</u> ADDRESS <u>4508 Eastern Ave</u> 24a. REC'D BY REGISTRAR <u>JUN 3 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Carl Smith</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 3 1957

RECEIVED

5049 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05032
Reg. Dist. No. 3376

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salapsaw		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Salapsaw			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sandymount Road				d. STREET ADDRESS Sandymount Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLENN Middle EUGENE Last BARRICK				4. DATE OF DEATH Month May Day 8 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12-1897		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton S. Barrick				14. MOTHER'S MAIDEN NAME Millie Mellett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-8248		17. INFORMANT Glenn E. Barrick Jr. Address Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes (c), stating the underlying cause last, DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1						INTERVAL BETWEEN ONSET AND DEATH minutes several yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES T. MARSH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11-1957		22c. NAME OF CEMETERY OR CREMATORY Emory Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Berryman + Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 5-9-57	
				24b. REGISTRAR'S SIGNATURE Mary B. Skye		DATE SIGNED 5/8/57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
BUREAU OF EXAMINERS' CERTIFICATE OF DEATH

BUREAU V. B.

MAY 15 1957

RECEIVED

5050

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leather</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leather</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>WILSON</u> Last <u>BEALL</u>		4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Dorsey Beall</u>		14. MOTHER'S MAIDEN NAME <u>Emma Boyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Emma Spurrin - Leather, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest, Arteriosclerosis, 1991</u> DUE TO (b) <u>CARCINOMA of Left ear, Anemia,</u> DUE TO (c) <u>Cerebral Thrombosis -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1955</u> <u>May 1957</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>57</u> , to <u>May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9 May</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>9 May 57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5-10-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harvey Allen</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 13 1957

RECEIVED

5051

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo, 23 dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11		3/21/57 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 808 Powers Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucy Middle Virginia Last NEW BELTON		4. DATE OF DEATH Month May Day 20 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1883
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR: Months 73 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter New		14. MOTHER'S MAIDEN NAME Judith Currell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-7875D	
17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion H2C-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 min. years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 27, 1957 , to May 20, 1957 , that I last saw the deceased alive on May 20, 1957 , and that death occurred at 1:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 5/20/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-23-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) East North Avenue, Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc. ADDRESS 1735 Harford Avenue, Baltimore, Md.		24a. REC'D BY REGISTRAR 5/30/57	24b. REGISTRAR'S SIGNATURE C. Harry Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05035

5052

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silverville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN 1b <u>7 Months</u>		d. STREET ADDRESS <u>14628 Colesville Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Bradbury</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLERK</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> years <u>443X</u> DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with arrhythmic disturbance with cerebral arteriosclerosis with myelotic degeneration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>10-5-1956</u> to <u>5-18-1957</u> that I last saw the deceased alive on <u>5-18-1957</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertie Soumefield</u>		M.D. <u>Springfield State Hospital, Springfield, MD</u>	
PHYSICIAN'S NAME (Type) <u>Gertie Soumefield M.D.</u>		<u>Springfield State Hospital, Springfield, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	22d. LOCATION (City, town, or county) <u>BUTLAND MD</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		ADDRESS <u>8434 9th Ave Silver Spring MD</u>	
24a. REC'D BY REGISTRAR <u>5/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Edgewood</u>	

BUREAU V. 81

AY -2 1957

RECEIVED

5041

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b 34 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 53 Pennsylvania Ave.			
d. STREET ADDRESS 53 Pennsylvania Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Jane Last Brown				4. DATE OF DEATH Month May Day 12 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 1860	
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months 96 Days 96 Hours 96 Min 96		IF UNDER 24 HRS Months 96 Days 96 Hours 96 Min 96			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Daniel Reese				14. MOTHER'S MAIDEN NAME Margaret Warehime			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO no		17. INFORMANT Noah L. Schaeffer Address Westminster, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial degeneration DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) marked edema				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 38.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Westminster				20g. (County) Carroll		20h. (State) Md.	
21. I certify that I attended the deceased from July 1954 to 5-12-1957 that I last saw the deceased alive on May 11, 1957 , and that death occurred at 2 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Kemper Ave. Westminster, Md.				DATE SIGNED 5/13/57			
ACTUAL SIGNATURE E. Reese Wilkens M.D.							
PHYSICIAN'S NAME (Type) E. Reese Wilkens M.D.				ADDRESS 15 Kemper Ave. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-57		22c. NAME OF CEMETERY OR CREMATORY Leisters Cemetery		22d. LOCATION (City, town, or county) (State) nr. Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminister, Maryland				24a. REC'D BY REGISTRAR DATE 5-14-57		24b. REGISTRAR'S SIGNATURE Hannett Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

MAY 16 1957

RECEIVED

5053

CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				d. STREET ADDRESS <u>MAIN ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>SADIE VIRGINIA COE</u>				4. DATE OF DEATH Month Day Year <u>MAY 2 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 4-1897</u>	
9. AGE (If years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM CRABBS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET HAINES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MERLE R. COE, NEW WINDSOR MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> <u>STROKE</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>year</u> <u>year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1955</u> , to <u>May 2</u> , 1957, that I last saw the deceased alive on <u>Apr 29</u> , 1957, and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Washington</u> DATE SIGNED <u>md</u>							
ACTUAL SIGNATURE <u>James T. Marsen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas Hartzler Sons New Windsor, Md</u>				24. REC'D BY REGISTRAR <u>DATE MAY 6 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Ernie Benedict</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 6 1957

RECEIVED

5954

CERTIFICATE OF DEATH

Reg. Dist. No.

19

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winfield				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 6 Westminster				e. STREET ADDRESS Rural--Westminster			
3. NAME OF DECEASED (Type or print) GERTRUDE P. COVER				4. DATE OF DEATH Month MAY Day 30 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1879		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James Peddicord				14. MOTHER'S MAIDEN NAME Ella Musgrove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Ernest T. Cover,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular disease DUE TO (c) senile changes							INTERVAL BETWEEN ONSET AND DEATH 3 days 15-20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935 , 19____, to 30 May , 19 57 , that I last saw the deceased alive on 30 May , 19 57 , and that death occurred at 6:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Liberty Road at Eldersburg DATE SIGNED 5/30/57							
ACTUAL SIGNATURE Wm. H. Lawson, Jr. M.D.				PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 6-1-1957		22c. NAME OF CEMETERY McKendree	
23. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR JUN 3 1957	
24b. REGISTRAR'S SIGNATURE M. E. F. 1957							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1957

RECEIVED

5055

CERTIFICATE OF DEATH

05761

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 1yr. 7 mos. 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1719 N. Montford Ave.	
3. NAME OF DECEASED (Type or print) First Sophie Middle Vock Last DUERR		4. DATE OF DEATH Month May Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1876
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired cook		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Naturalized-USA	
13. FATHER'S NAME John Vock		14. MOTHER'S MAIDEN NAME Elizabeth Waber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) None (c) None		INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Fracture of olecranon, right, closed.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 4, 1955 to May 16, 1957 , that I last saw the deceased alive on May 16, 1957 , and that death occurred at 10:50 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 5/16/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William C. Vock, Jr.		24a. REC'D BY REGISTRAR 5/17/57	
ADDRESS 1217 1/2 Paul St. Balto.		24b. REGISTRAR'S SIGNATURE C. Henry Brown	

FUREAU V. B.

24 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5042

CERTIFICATE OF DEATH

05039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 Liberty St.		d. STREET ADDRESS 49 Liberty St.	
3. NAME OF DECEASED (Type or print) First Henry Nicholas Middle Eckstine Last Eckstine		4. DATE OF DEATH Month May Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 13 Hours 13 Min. 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Cons.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Eckstine		14. MOTHER'S MAIDEN NAME Anna Briers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-9330	
17. INFORMANT Mrs. Fannie C. Eckstine		Address Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial degeneration DUE TO (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Several yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 100.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1957 to May 13, 1957 that I last saw the deceased alive on May 13, 1957 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Glenn Speicher		ADDRESS (Street, city or town, state) Westminster Md. DATE SIGNED 5/13/57	
PHYSICIAN'S NAME (Type) W. Glenn Speicher M.D.		135 E. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-15-57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR DATE 5-14-57		24b. REGISTRAR'S SIGNATURE Harriet Miller	

BUREAU V. B.

MAY 16 1957

RECEIVED

5056

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville, Maryland c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3021-4 d. STREET ADDRESS 1216 Greenmount Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edith Estella Ford				4. DATE OF DEATH Month Day Year 5 29 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-1910	
9. AGE (In years last birthday) 46 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? none		13. FATHER'S NAME Anthony Ford		14. MOTHER'S MAIDEN NAME Elizabeth Florafle (Kreafle)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic rheumatic heart disease 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with mental deficiency with psychotic							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) reaction			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) reaction	
20f. (City or town) reaction				20g. (County) reaction		20h. (State) reaction	
21. I certify that I attended the deceased from 5-22 19 57 , to 5-29 19 57 , that I last saw the deceased alive on 5-29 19 57 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Maryland DATE SIGNED 5-29-1957							
ACTUAL SIGNATURE Ilse Kamm M.D. Springfield State Hospital, Sykesville, Maryland							
PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1957		22c. NAME OF CEMETERY OR CREMATORY St Johns Luthern Cemetery		22d. LOCATION (City, town, or county) (State) 8600 Harford Road, Balto:Co.Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc.				ADDRESS -1735 Harford Avenue, Balto:Co.Md.		24a. REC'D BY REGISTRAR 31 1957	
24b. REGISTRAR'S SIGNATURE C. Harry [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 24 1957

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05041

5057

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakland Mills Rd.</u>		d. STREET ADDRESS <u>Oakland Mills Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>F.</u> Last <u>Hilliard</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Private Chauffeur (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bernard Hilliard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Campell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World No. I</u>		16. SOCIAL SECURITY NO. <u>World No. I</u>	
17. INFORMANT <u>Mrs. Hilda Hilliard - Oakland Mills Rd., Sykes-</u>		Address <u>ville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Agitans</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1956</u> to <u>5 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 May, 1957</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/7/57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Steers</u>			

BUREAU V. S.

MAY 8 1931

RECEIVED

5043

CERTIFICATE OF DEATH

05042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>216 E. Main St.</u>				d. STREET ADDRESS <u>216 E. Main St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FRANCIS HOFFMAN</u>				4. DATE OF DEATH Month Day Year <u>May 17 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 6, 1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Hoffmann</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (If yes, give war or dates of service) <u>—</u>				17. INFORMANT Address <u>Miss Helma Hoffman, Westminster Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiovascular disease</u> <u>422.1</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 15, 1937</u> , to <u>5-18, 1957</u> , that I last saw the deceased alive on <u>May 14, 1957</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>5-18-57</u>			
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. August Miller</u>	

BUREAU V. S.

NOV 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5058 CERTIFICATE OF DEATH

05043

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARVEY Middle LEWIS Last HORSEY		4. DATE OF DEATH Month May Day 9 Year 19 57	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1877
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Allen Horsey	
14. MOTHER'S MAIDEN NAME Rachel Evans		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 212-30-2858		17. INFORMANT Address Mrs. Edna Ghee, Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease with arteriosclerosis and chronic myocarditis DUE TO (b) senile changes DUE TO (c) senile changes CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.			INTERVAL BETWEEN ONSET AND DEATH 30 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1935 , 19____, to 9 May , 19 57 , that I last saw the deceased alive on 9 May , 19 57 , and that death occurred at 4:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) DATE SIGNED Liberty Road at Eldersburg 5.9.57	
PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		ADDRESS Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-13-1957	22c. NAME OF CEMETERY OR CREMATORY Johnsville	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE 5/13/57		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BUREAU V. K.

AV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5059

CERTIFICATE OF DEATH

05044

Reg. Dist. No. 14

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Maryland</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 23 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u> <u>15X1</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Daisy Florence Howes</u>				4. DATE OF DEATH Month Day Year <u>May 22 19 57</u>			
5. SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. Wachter</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Craver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>744</u>		17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brachiovascular heart disease</u> DUE TO (c) <u>Cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome, assoc. with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>351X</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Unity</u>				20g. (County) <u>Maryland</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>4-8</u> , 19 <u>57</u> , to <u>5-22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-22</u> , 19 <u>57</u> , and that death occurred at <u>1:32 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrude Spruett M.D. Springfield State Hospital Sykesville Md.</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital Sykesville Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gertrude Spruett M.D. Springfield State Hospital Sykesville Md.</u>				DATE SIGNED <u>5/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Unity Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W. BARBER</u>				ADDRESS <u>Laytonville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/28/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harry E. Egan</u>			

RECEIVED

MAY 29 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

74

5060

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 13, Md</u>	
c. LENGTH OF STAY IN TB <u>3 years</u>		d. STREET ADDRESS <u>1622 N. Milton Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>James</u> Last <u>Jacobs</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-86</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>telephone operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Scanlon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-12-2971A</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4d.O.O. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 20, 1954</u> to <u>May 2, 1957</u> , that I last saw the deceased alive on <u>May 3, 1957</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund B. Lusthaus</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>5-4-57</u>	
PHYSICIAN'S NAME (Type) <u>Edmund B. Lusthaus</u>		<u>Sykesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-7-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church of the Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Sangersville Virg</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u> ADDRESS <u>-2431 E. Oliver St.</u>		24a. REC'D BY REGISTRAR <u>MAY 7 1957</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 2 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05046

Reg. Dist. No. 74

5061

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 26</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3627 Greenmount Ave.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Manville Ernest Kefauver</u>				4. DATE OF DEATH Month Day Year <u>May 19, 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1914</u>		9. AGE (In years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Manville Kefauver</u>				14. MOTHER'S MAIDEN NAME <u>Laura Lightner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>214-10-5445</u>		17. INFORMANT <u>Mrs. Miriam R. Kefauver</u> Address <u>Frederick, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemorrhage due to gunshot wound of abdomen</u> DUE TO <u>abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>976x</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in abdomen</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>3 p.m.</u> <u>5/19/57</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>car</u>		20f. (City or town) (County) (State) <u>Sykesville Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>5/20/57</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Md.</u> ADDRESS						24a. REC'D BY REGISTRAR DATE <u>5/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>(Signature)</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957
RECEIVED

5062

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1 mo 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3519 Greenmount Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Teresa Middle Camilla Last Klinefelter		4. DATE OF DEATH Month 5 Day 22 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-79
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 22 Hours 19 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never gainfully employed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Klinefelter		14. MOTHER'S MAIDEN NAME Jane Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile asthenia 704.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus ulcers DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH weeks plus weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chron. brain syndr. assoc with cerebr. arterioscler. with psych reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fract. of right head of humerus acquired prior to admission to this hospital	
20c. TIME OF INJURY Month 4-7-57 Day 19 Hour a. 11 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Baltimore City (County) (State)	
21. I certify that I attended the deceased from 4-12- 19 57 , to 5-22- 19 57 , that I last saw the deceased alive on 5-22- 19 57 , and that death occurred at 9 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 5-22-57			
ACTUAL SIGNATURE Edmund Lusthaus		PHYSICIAN'S NAME (Type) Edmund Lusthaus	
22a. BURIAL, CREMATION, RECOVAL (Specify) Burial		22b. DATE THEREOF 5-25-57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) Balto Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford		24a. REC'D BY REGISTRAR 5/23/57 24b. REGISTRAR'S SIGNATURE C. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 27 1957

BUREAU V. S.

5-63

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shysville</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>D.</u> Last <u>LEWIS</u>				4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 31, 1867</u>	
9. AGE (in years last birthday) <u>89</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Arnold T. Lewis</u>			
14. MOTHER'S MAIDEN NAME <u>Burdette</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO <u>none</u>				17. INFORMANT <u>Mrs. Anna Shimer</u> Address <u>Shysville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO <u>1 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Several Anterior attacks of C.V.A.</u> DUE TO <u>Generalized Arterio-sclerosis</u> (c) <u>multiple chronic arthritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs</u> <u>30 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>multiple chronic arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>September 1953</u> to <u>May 1957</u> , that I last saw the deceased alive on <u>May 8, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>37 Central Ave. Shysville, Md.</u>				DATE SIGNED <u>5/9/57</u>			
ACTUAL SIGNATURE <u>Bertrand R. Gall</u>				M. D. <u>37 Central Ave. Shysville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Bertrand R. Gall</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boyd's Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Boyd's, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubert H. Haight</u> ADDRESS <u>Shysville, Md.</u>				24a. REC'D BY REGISTRAR <u>C. Harry Wier</u> DATE <u>5-10-57</u>			
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5964

CERTIFICATE OF DEATH

Reg. Dist. No.

05059

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> City <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>3 mo 12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Emanuel</u> Last <u>Libertini</u>				4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-79</u>		9. AGE (In years last birthday) <u>77</u> yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. natur.</u>							
13. FATHER'S NAME <u>James Libertini</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Saverino</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-0265A</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Encephalopathy</u> <u>454X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Thrombosis of lenticulostriate artery</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1-21</u> , 1957, to <u>May 3</u> , 1957, that I last saw the deceased alive on <u>May 3</u> , 1957, and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edmund B. Lusthaus</u> M.D. <u>Springfield State Hospital</u> <u>5-4-57</u> PHYSICIAN'S NAME (Type) <u>Edmund B. Lusthaus</u> <u>Sykesville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>1430 Belair Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Vecchia</u>				ADDRESS <u>322 S. High St.</u>		24a. REC'D BY REGISTRAR DATE <u>5/7/57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Sherr</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 8 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5065

CERTIFICATE OF DEATH

Reg. Dist. No.

05051

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 3 yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 725 Montford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lena (Michalina) Lubinska		4. DATE OF DEATH Month Day Year May 13 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-73 May 18, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Anthony ? Truskowski		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-09-9912	
17. INFORMANT Mr. John Truskowski		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease, with INTERVAL BETWEEN ONSET AND DEATH Few hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 10)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-5 , 19 54 , to 5-13 , 19 57 , that I last saw the deceased alive on 5-13 , 19 57 , and that death occurred at 1:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerhard Sonnenfeldt M.D.		DATE SIGNED 5/13/57	
PHYSICIAN'S NAME (Type) Gerhard Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Holy Rosary	22d. LOCATION (City, town, or county) (State) German Hill Rd Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		24a. REC'D BY REGISTRAR DATE 5/13/57	
24b. REGISTRAR'S SIGNATURE Missy			

REAU V. B.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 17 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 01 X 2. 2	
3. NAME OF DECEASED (Type or print) First Randolph Middle McDonald Last McDonald		4. DATE OF DEATH Month May Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1901 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk -	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry McDonald		14. MOTHER'S MAIDEN NAME Bessie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Miss J. McDonald, Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive hemorrhage due to stab wounds of chest 982 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIF.CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Carroll Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-57	
22c. NAME OF CEMETERY OR CREMATORY Rural Hill		22d. LOCATION (City, town, or county) (State) Moscow Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Est. Bond - Westminster, Md.		24a. REC'D BY REGISTRAR DATE 5/15/57	
		24b. REGISTRAR'S SIGNATURE C. Harry Wew	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

BUREAU V. M.

1957

RECEIVED

5067

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 2801 N. Calvert Street			
3. NAME OF DECEASED (Type or print) First Norma Middle Maria Last Meixner				4. DATE OF DEATH Month 5 Day 24 Year 19 57			
5 SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-01		9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John A. Meixner			
14. MOTHER'S MAIDEN NAME Loua Turner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. no				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, undiffer.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Carroll		20h. (State) Md.	
21. I certify that I attended the deceased from 5-13-57 , 19 57 , to 5-24- , 19 57 , that I last saw the deceased alive on 5-24- , 19 57 , and that death occurred 9:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 5-25-57							
ACTUAL SIGNATURE Edmund Lustbars				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Edmund Lustbars				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/27/57		22c. NAME OF CEMETERY OR CREMATORY Independent Order Odd Fellows Cem.		22d. LOCATION (City, town, or county) (State) Marion, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tichner				ADDRESS North W. Ave.		24a. REC'D BY REGISTRAR 24715	
				24b. REGISTRAR'S SIGNATURE R. E. Henry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 11 1907

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5068
CERTIFICATE OF DEATH

05054

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 10mos. 8days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Esther Sophia Schlueter Middle OBERMAN Last		4. DATE OF DEATH Month May Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Schlueter		14. MOTHER'S MAIDEN NAME Anna Brenker -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-01-6805 D	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Generalized arteriosclerosis DUE TO (c) 175 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Hours Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease with psychotic reaction. Cystadenocarcinoma of ovary. (Operated on in 1934)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1955 to May 9, 1957 , that I last saw the deceased alive on May 9, 1957 , and that death occurred at 8:45 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 5/10/57			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/57	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
22d. LOCATION (City, town, or county) Pikesville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner		24a. REC'D BY REGISTRAR DATE 5/10/57	
24b. REGISTRAR'S SIGNATURE Wm. J. Tichner			

NAVY

1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5069

CERTIFICATE OF DEATH

05055

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs.4mos.16days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. STREET ADDRESS 238 West Side Ave.,			
3. NAME OF DECEASED (Type or print) First Millie Middle Elizabeth Last Cunningham PALMER				4. DATE OF DEATH Month May Day 9, Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Cunningham				14. MOTHER'S MAIDEN NAME Katherine -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Marasmus Decubitus ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUPLICATE (b) DUE TO (c) C.B.S. associated with circulatory disturbance, with cerebral arterio-sclerosis, with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Oct. 20, 19 54, to May 9, 19 57, that I last saw the deceased alive on May 9, 19 57, and that death occurred at 8:47 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield Hospital		DATE SIGNED 5/10/57	
PHYSICIAN'S NAME (Type) Edmund Lusthaus				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/57		22c. NAME OF CEMETERY OR CREMATORY Broadway Cemetery near Coopers, Md		22d. LOCATION (City, town, or county) (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Hoffman				ADDRESS Hagerstown		24a. REC'D BY REGISTRAR DATE 5-10-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Wilson			

STANLEY V. E.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5070
CERTIFICATE OF DEATH

05056

Reg. Dist. No. *74*

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard 153			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage 137			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Thomas Middle Foley Last Pattison				4. DATE OF DEATH Month 5 Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-70	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morton Pattison				14. MOTHER'S MAIDEN NAME Frances Chamberlain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. <i>unk.</i>		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH minutes
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion							
120.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Hypertensive arteriosclerotic heart disease							years
(c) Generalized arteriosclerosis							years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
Chronic brain syndrome due to cerebral arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18) <i>374</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 5-25 , 19 57 , to 5-28 , 19 57 , that I last saw the deceased alive on 5-28- , 19 57 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Sykesville							
ACTUAL SIGNATURE <i>Agustin del Campo</i>				M.D. Springfield State Hospital Md. 5-28-57			
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.							
22a. BURIAL, CREMATION, or other disposal		22b. DATE THEREOF		22c. NAME OF GENETIC OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>5-28-57</i>		<i>Christ Church</i>		<i>Quilford Howard Co</i>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REG. DAY REGISTRAR	
<i>Dr. W. L. Donaldson</i>				<i>Towson Md</i>		24b. REGISTRAR'S SIGNATURE	
				DATE <i>5/30/57</i>		<i>C. H. H. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

5- 1957

RECEIVED

05057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R.D.1 (Myers District)		d. STREET ADDRESS Westminster, Md. R.D.1 (Myers Dist)	
3. NAME OF DECEASED (Type or print) Alverta Mae Powell		4. DATE OF DEATH Month May Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1874
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Fowler		14. MOTHER'S MAIDEN NAME Charlotte Lambert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry M. Powell		Address Harry M. Powell, Westminster, Md. R.D.1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension & arteriosclerosis (b) Cardiovascular disease DUE TO Myocardial degeneration (c) Cerebral degeneration			
INTERVAL BETWEEN ONSET AND DEATH 17 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1945 to May 25, 1957 , that I last saw the deceased alive on May 24, 1957 , and that death occurred at 9:30 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Glenn Speicher		DATE SIGNED May 25, 1957	
PHYSICIAN'S NAME (Type) W. GLENN SPEICHER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May, 28, 1957	
22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DATE 5-28-57		24b. REGISTRAR'S SIGNATURE Wm. F. Miller	

BUREAU V. S.

MAY 28 1957

RECEIVED

5072

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) Henryton State Hospital		d. STREET ADDRESS 925 Eastern Avenue	
3. NAME OF DECEASED (Type or print) First Ruth Middle Raymond Last Raymond		4. DATE OF DEATH Month 5 Day 3 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1917
9. AGE (In years last birthday) 40 yrs		10. IF UNDER 1 YEAR: Months 40 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nelson Williams		14. MOTHER'S MAIDEN NAME Bessie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Ruth Raymond - Patient	
17. INFORMANT Ruth Raymond - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory pulmonary TB. 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-23- 1954 , to 5-3- 19 57 , that I last saw the deceased alive on May 3, 19 57 , and that death occurred at 7:20 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. F. Vestal		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 5-3-57			
PHYSICIAN'S NAME (Type) Tom. F. Vestal, Supt.		Henryton State Hospital, Henryton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-7-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Williams, Jr.		ADDRESS 467 N. St. N. W. Wash. D. C.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Albert R. Swannham	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 6 1937

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 25 y 4 m 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3100 St. Paul Str.			
3. NAME OF DECEASED (Type or print) First Thomas Middle L. Last Roddy				4. DATE OF DEATH Month 3 (May) Day 5 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-12-83		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Roddy				14. MOTHER'S MAIDEN NAME Susan Tally			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic valvulitis, inactive with deformity of mitral valve 41 X Sub-acute suppurative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. a) Chronic pancreatitis DUE TO (c) Chronic brain syndrome due to alcoholism							INTERVAL BETWEEN ONSET AND DEATH years weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to alcoholism							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20- , 1954, to 5-4- , 1957, that I last saw the deceased alive on 5-4- , 1957, and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund B. Lusthaus M.D. Springfield State Hospital 5-5-57							
ACTUAL SIGNATURE Edmund B. Lusthaus M.D. Springfield State Hospital 5-5-57							
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus Sykesville, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight				24a. REC'D BY REGISTRAR DATE 5-6-57		24b. REGISTRAR'S SIGNATURE C. Harry Elder	

BUREAU V. S.

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5074

CERTIFICATE OF DEATH

05060

Reg. Dist. No. 74

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY M	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Sykesville Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 4524 Middleton Lane	
3. NAME OF DECEASED (Type or print) First Ethel Middle Ronaldson Last		4. DATE OF DEATH Month May Day 13 Year 19 57	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School	9. AGE (In years last birthday) 72 yrs
11. BIRTHPLACE (State or foreign country) Mass. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Ronaldson		14. MOTHER'S MAIDEN NAME Annie Condell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO unk	
17. INFORMANT Records—Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction with pericardial hemorrhage DUE TO 4x0.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with arteriosclerosis, with psychotic			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) reaction	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1 , 19 57 , to May 13 , 19 57 , that I last saw the deceased alive on May 13 , 19 57 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED			
ACTUAL SIGNATURE Gertrude M. Gross, M.D.		PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D. Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Cremation	5-14-57	Fort Lincoln	Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		24a. REC'D BY REGISTRAR 5-13-57	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE C. Harty	

MEDICAL CERTIFICATION

T HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU VI

15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5975

CERTIFICATE OF DEATH

05061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
c. LENGTH OF STAY IN 1b <u>2 years</u>				d. STREET ADDRESS <u>513 Schuyler Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Hannah Rozelle</u>				4. DATE OF DEATH Month Day Year <u>5 - 24 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-1-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Boxer</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Thorne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <u>Springfield State Hospital, Sykesville</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>400</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated a disturbance of metabolism with inhibition a severe brain disease a psychotic reaction</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>34x</u> 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>6-23-1955</u> to <u>5-24-1957</u> , that I last saw the deceased alive on <u>5-24-1957</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Bertrand Souneyfeldt</u> M.D. <u>Springfield State Hospital Sykesville Md.</u> PHYSICIAN'S NAME (Type) <u>Bertrand Souneyfeldt M.D. Springfield State Hospital Sykesville Md.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>5/28/1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u> 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>MARTIN W. HYSOING COMPANY 1300 N. STREET, N.W. WASHINGTON, D.C.</u> 24a. REC'D BY REGISTRAR DATE <u>MAY 20 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Garry Hays</u>							

RECEIVED

MAY 28 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5075

CERTIFICATE OF DEATH

05062
Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Patapsco	
3. NAME OF DECEASED (Type or print) First Albert Middle Oliver Last Schaeffer		4. DATE OF DEATH Month May Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1895 61 yrs.
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Buildings	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph H. Schaeffer		14. MOTHER'S MAIDEN NAME Sarah J. Buchen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW I		16. SOCIAL SECURITY NO. 220-18-2037	
17. INFORMANT Mrs. N. Thelma Schaeffer		Address Patapsco, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pericarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/3 19 57 to 4/3 19 57 that I last saw the deceased alive on 4/3 19 57 and that death occurred at 11 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Maryland DATE SIGNED 4/3/57			
ACTUAL SIGNATURE Shirley Bare M.D.		PHYSICIAN'S NAME (Type) S. Luther Bare M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-6-57	
22c. NAME OF CEMETERY OR CREMATORY Patapsco Cemetery		22d. LOCATION (City, town, or county) (State) Patapsco Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR DATE 5-4-57		24b. REGISTRAR'S SIGNATURE Heinrich G. G. G.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 6 1957

BUREAU V. S.

CERTIFICATE OF DEATH

05063 78
Reg. Dist. No.

5077

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 6 Westminster Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANDREW Middle G. Last SHAFER		4. DATE OF DEATH Month May , Day 6th , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Andrew G. SHAFER		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Geo. Detmer Address Box 246 Randallstown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Anterograde Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Semility DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 15, 1957 , to May 6, 1957 , that I last saw the deceased alive on May 5, 1957 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius Chepko		ADDRESS (Street, city or town, state) 8526 Ave. St. Westminster Md	
PHYSICIAN'S NAME (Type) Julius Chepko		DATE SIGNED 3/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/8/56	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem	22d. LOCATION (City, town, or county) (State) Woodlawn Md
23. FUNERAL DIRECTOR'S SIGNATURE E. Mello Kamoreau ADDRESS Liberty Rd Baltimore		24a. REC'D BY REGISTRAR MAY 9 1957	24b. REGISTRAR'S SIGNATURE May T. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 9 1957

RECEIVED

5041

CERTIFICATE OF DEATH

05064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 152 E. Main St.		d. STREET ADDRESS 152 E. Main St.	
3. NAME OF DECEASED (Type or print) Walter Carroll Shunk		4. DATE OF DEATH May 1 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1886
9. AGE (in years) 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Banker		10b. KIND OF BUSINESS OR INDUSTRY National Bank	
11. BIRTHPLACE (State or foreign country) Westminster, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME J. Walter Shunk		14. MOTHER'S MAIDEN NAME Margaret Anders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. 216-14-5794	
17. INFORMANT Mrs. Irene B. Shunk		Address Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis, Myocarditis (old) 592x DUE TO Hypertension (old) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1945 to May 1, 1957 that I last saw the deceased alive on Apr 30, 1957 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Jennette		DATE SIGNED 5-1-57	
PHYSICIAN'S NAME (Type) W. C. Jennette, M.D.		ADDRESS 103 E. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-3-57	22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery	22d. LOCATION (City, town, or county) (State) Westminster, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR 5-4-57		24b. REGISTRAR'S SIGNATURE W. C. Jennette	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

MAY 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5078
CERTIFICATE OF DEATH

05065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 24 College Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Burley Edward Spriggs, Jr.				4. DATE OF DEATH Month 5 Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 9, 1923	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Carrier		10b. KIND OF BUSINESS OR INDUSTRY Johnson's Company		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Burley Edward Spriggs, Sr.				14. MOTHER'S MAIDEN NAME Sadie Mahoney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-7210		17. INFORMANT Burley Edward Spriggs, Jr.-24 College Ave. Address Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) advanced pulmonary pathology left c cavitation and pneumothorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculosis ?? Lung Abscess ?? DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 7, 1957 , to May 8, 1957 , that I last saw the deceased alive on May 8, 1957 , and that death occurred at 5 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE T.F. Vestal M.D.				ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 5-8-57	
NAME (Type) Dr. Tom F. Vestal, Supt.				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-12-57		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr.				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE	
						24b. REGISTRAR'S SIGNATURE Wm R. Swankhouse	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 10 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

0506674

5070

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5 mo 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3026 Pinewood Avenue			
3. NAME OF DECEASED (Type or print) First William Middle Anton Last Stickel				4. DATE OF DEATH Month 5 Day 24 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-73		9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Stickel				14. MOTHER'S MAIDEN NAME Louise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO unkn		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia (c) Infarction of brain due to embolism, cause unknown							INTERVAL BETWEEN ONSET AND DEATH years days days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebr. arterioscler. with psych. react.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-30- 19 56 , to 5-24- 19 57 , that I last saw the deceased alive on 5-24- 19 57 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 5-25-57							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/28/57		22c. NAME OF CEMETERY OR CREMATORY Wt. Hebron		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Thomas				ADDRESS Wm. L. Thomas		24a. REC'D BY REGISTRAR MAY 27 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 27 1957

BUREAU V. S.

5080

CERTIFICATE OF DEATH

05067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural New Windsor		c. LENGTH OF STAY IN b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Echo Hills		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / rural New Windsor	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Echo Hills		d. STREET ADDRESS / Echo Hills	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Luther Middle Clarence Last Stitely		4. DATE OF DEATH Month May Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1870
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months 8 Days 19 Hours 19 Min 57	IF UNDER 24 HRS. Months 8 Days 19 Hours 19 Min 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY General Prac.	
11. BIRTHPLACE (State or foreign country) Westminster, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Josiah Q. Stitely		14. MOTHER'S MAIDEN NAME Adelaide Eyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Mrs. Margaret E. Stitely		Address New Windsor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Hemorrhage DUE TO (c) Arterio-sclerotic C-V disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15 , 19 57 , to May 19 , 19 57 , that I last saw the deceased alive on May 19 , 19 57 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 109 E. Main St. Westminster, Md. DATE SIGNED ACTUAL SIGNATURE James T. Marsh M.D. PHYSICIAN'S NAME (Type) James T. Marsh M.D. 109 E. Main St. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-57	
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR DATE 5-21-57		24b. REGISTRAR'S SIGNATURE Harriet E. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

5081

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN b. 1 yrs. 7 mos. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3332 Keswick Road	
3. NAME OF DECEASED (Type or print) First Middle Last Anna Julia Hamilton SURRATT		4. DATE OF DEATH Month Day Year May 1, 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1906
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hamilton		14. MOTHER'S MAIDEN NAME Anna J. Bunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Springfield State Hospital Records.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic valvulitis, inactive, with deformity 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of valve. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, catatonic type.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital
20f. (City or town) Baltimore, Md.		(County) (State)
21. I certify that I attended the deceased from Oct 20, 1954 to May 1, 1957 , that I last saw the deceased alive on May 1, 1957 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 5/2/57 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-4-57	22c. NAME OF CEMETERY OR CREMATORY Catholics
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Burgess Funeral Home 363 Falls Rd Balto by Herman H. Burgess Jr		24a. REC'D BY REGISTRAR DATE 5-3-57
24b. REGISTRAR'S SIGNATURE C. Harry Green		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 7 1907

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23 Longwell Apts.				d. STREET ADDRESS 23 Longwell Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Lee Last Taylor				4. DATE OF DEATH Month May Day 17 Year 19 57			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 17	IF UNDER 24 HRS. Hours 17 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Cons.		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME K. R. Taylor				14. MOTHER'S MAIDEN NAME Mary Catherine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. 216-16-6053		17. INFORMANT Address Mrs. James E. Shilling Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic C-V disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH year						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-57		22c. NAME OF CEMETERY OR CREMATORY Carrollton Church of God Carrollton, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 5-18-57	
				24b. REGISTRAR'S SIGNATURE Harriet Miller		DATE SIGNED 5/18/57	

THIS MEDICAL EXAMINER'S CERTIFICATE should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5982

CERTIFICATE OF DEATH

05070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN lb 840 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS Route 3			
3. NAME OF DECEASED (Type or print) First Worrie Middle Goodlow Last Thomas				4. DATE OF DEATH Month May Day 27 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Denton, Maryland	
13. FATHER'S NAME James Thomas				14. MOTHER'S MAIDEN NAME Sarah Sharp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Worrie Goodlow Thomas - Patient	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral cavitory tuberculosis + DUE TO Neoplasm metasis; diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 7, 1955 , to May 27, 1957 , that I last saw the deceased alive on May 27, 1957 , and that death occurred at 2:45 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 5-27-57							
ACTUAL SIGNATURE Edgars M. Maculans				M.D. Henryton, Maryland			
PHYSICIAN'S NAME (Type) Edgars M. Maculans				HENRYTON STATE HOSPITAL, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1957		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or County) (State) Denton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moore & Son				ADDRESS Denton, Md		24a. REC'D BY REGISTRAR DATE	
						24b. REGISTRAR'S SIGNATURE Albert R. Frankham	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 29 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05071

Reg. Dist. No.

77

5083

1. PLACE OF DEATH a. COUNTY <u>Harrell</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harrell</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>19-S-Franklin town</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NETTIE PEARL THUMBERT</u> First Middle Last 4. DATE OF DEATH <u>May 29 1957</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 26 - 1886</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. - Sitter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Haw's</u> 11. BIRTHPLACE (State or foreign country) <u>Salisbury - Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		9. AGE in years last birthday 13. FATHER'S NAME <u>John Twigg</u> 14. MOTHER'S MAIDEN NAME <u>Mary A. White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>William Howard</u> Address <u>19-S-Franklin town</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury to chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>5/29 1957</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 30</u> 20f. (City or town) <u>Greenmount</u> (County) <u>Harrell</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T. Marsh</u> EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 22b. DATE THEREOF <u>June 1-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Lauder Park</u> 22d. LOCATION (City, town, or county) <u>Baltimore - Md</u>		23. FLINERAL DIRECTOR'S SIGNATURE <u>W. B. Clippert</u> ADDRESS <u>1300 Eastern Ave</u> 24a. REC'D BY REGISTRAR <u>W. B. Clippert</u> 24b. REGISTRAR'S SIGNATURE <u>W. B. Clippert</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

REAU V. B.

1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

5084

CERTIFICATE OF DEATH

Reg. Dist. No.

05762

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
c. LENGTH OF STAY IN 1b <u>4 years</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Harvey</u> Last <u>Truett</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1957</u>	
6. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-13-69</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Truett</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Harvey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>4041</u>		17. INFORMANT Address <u>Springfield State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive heart failure</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis in a manic-depressive personality</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4041</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-6-1947</u> to <u>5-18-1957</u> , that I last saw the deceased alive on <u>5-18-1957</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Esther Soumireu</u> M.D. <u>Springfield State Hospital Sykesville Md.</u>			
PHYSICIAN'S NAME (Type) <u>Esther Soumireu Springfield State Hospital Sykesville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>5/19/57</u> 24b. REGISTRAR'S SIGNATURE <u>C. H. Hargrave</u>	

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BUREAU V. I.

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05763

5085

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Baltimore,			
f. STREET ADDRESS 2000 N. Calvert St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice C. Middle Ward Last WAGNER				4. DATE OF DEATH Month May Day 13, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1872	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Ward				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease H20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with arteriosclerosis with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto	(County) md.	(State) md.		
21. I certify that I attended the deceased from May 4, 19 57 to May 13, 19 57 , that I last saw the deceased alive on May 13, 19 57 , and that death occurred at 4:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield Hospital			DATE SIGNED 5/13/57		
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl	22d. LOCATION (City, town, or county) Balto	(State) md.			
23. FUNERAL DIRECTOR'S SIGNATURE John P. Toulfel		ADDRESS 5311 Edmondson Ave		24a. REC'D BY REGISTRAR DATE 5/13/57	24b. REGISTRAR'S SIGNATURE C. Harry Wilson		

BUREAU V. 4

MAY 15 1957

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5486

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 34yrs. 8mos. 22days			
d. NAME OF HOSPITAL (If not in hospital give street address) Springfield State Hospital				d. STREET ADDRESS -			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Fred Middle Miller Last WAGNER				4. DATE OF DEATH Month May Day 29 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel C. Wagner				14. MOTHER'S MAIDEN NAME Fannie V. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic nephrosis 002 X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis of the lung, far advanced DUE TO (c) 5 yrs. plus							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 1, 1950 to May 29, 1957 , that I last saw the deceased alive on May 29, 1957 , and that death occurred at 7:55A M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 5/29/57			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Interment		22b. DATE THEREOF June 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Boonsboro Mausoleum		22d. LOCATION (City, town, or county) (State) Boonsboro Wash. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR JUN 3 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry King			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 3 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5087

CERTIFICATE OF DEATH

05073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 mos. 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital	
d. STREET ADDRESS 3320 Brendan Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle Vaeth Last WARD		4. DATE OF DEATH Month May Day 28 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1886
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rooming house operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Adam Vaeth		14. MOTHER'S MAIDEN NAME Elizabeth Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic rheumatic heart disease 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with circulatory disturbance with cerebral arteriosclerosis with psychosis. Nodular goiter.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1956 , to May 28, 1957 , that I last saw the deceased alive on May 28, 1957 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED Walther H. Sonnenfeldt			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		22. LOCATION (City, town, or county) (State) Baltimore, Md.	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 6/1/57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS Funeral Home 3331 Brehms Lane		24. RECEIVED BY REGISTRAR JUN 3 1957 24b. REGISTRAR'S SIGNATURE W. H. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 3 1957
BUREAU V. 31

5088

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, Md</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>200 South Main St</u>		d. STREET ADDRESS <u>200 S. Main St</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Clinton</u> Last <u>Warner</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 14, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Quench</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Warner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Reese</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>331X</u>	
17. INFORMANT Address <u>Mrs Anna Warner, Manchester, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>44</u> DUE TO <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiac Vascular Disease</u>		(c) <u>(?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> 19 <u>40</u> to <u>May 29</u> 19 <u>57</u> that I last saw the deceased alive on <u>May 29</u> 19 <u>57</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u>	
DATE SIGNED <u>7/29/57</u>		22a. NAME OF CEMETERY OR CREMATORY <u>Carroll Co. Md</u>	
22b. DATE THEREOF <u>June 1/57</u>		22c. LOCATION (City, town, or county) (State) <u>Carroll Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Tipton</u>		ADDRESS <u>Hampstead, Md</u>	
24a. REC'D BY REGISTRAR <u>May 30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Mrs. Danner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 5 1957
BUREAU V. S.

5089

CERTIFICATE OF DEATH

0507574
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard 15h Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 8019 Ridgley Oak Road	
3. NAME OF DECEASED (Type or print) First Alberta Middle Murray Last Wells		4. DATE OF DEATH Month May Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-71
9. AGE (In years and birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Murray		14. MOTHER'S MAIDEN NAME Lee Anna Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 4438	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4438X not DUE TO Arteriosclerotic cardio-vascular disease with Hypertention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 9057 (b) Fracture rt.hip underlying but not contributing directly to death. (c) INTERVAL BETWEEN ONSET AND DEATH days years 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While going to the laboratory she slipped and fell injured rt.hip	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 5- 7-157		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work Hospital.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sykesville		20f. (City or town) (County) (State) Carroll Md/	
21. I certify that I attended the deceased from 1-30-56 , 19 56 , to 5-12-57 , 19 57 , that I last saw the deceased alive on 5-12-57 , 19 57 , and that death occurred at 5.15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 5-12-57			
ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital.			
PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.			
22a. BURIAL, CREMATION, OR DISPOSITION (Specify) Burial		22b. DATE THEREOF 5/15/57	
22c. NAME OF CEMETERY OR CREMATORY Trinity Chapel		22d. LOCATION (City, town, or county) (State) Howard Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		24a. REC'D BY REGISTRAR DATE 5/12/57	
24b. REGISTRAR'S SIGNATURE C. Harry Edman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, address, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
 MAY 14 1957
 BUREAU V. 4

5090

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN IB 14 yrs, 6 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norman Middle D. Last YOST		4. DATE OF DEATH Month May Day 13 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1925
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months 31 Days 13 Hours 19 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Pittsburgh Plate Glass Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert Yost		14. MOTHER'S MAIDEN NAME Anna Lindenmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous peritonitis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Moderately advanced tuberculosis of the lungs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, catatonic type. Tuberculosis of hip and ankle joints.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 to May 13, 1957 , that I last saw the deceased alive on May 13, 1957 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 5/13/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF May 15/57	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. A. Witke		24. RECEIVED BY REGISTRAR DATE 5/15/57	
25. REGISTRAR'S SIGNATURE C. Harry Weir		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

MAY 15 1957

RECEIVED

MAY 16 1957
WILLIAM P. MURPHY, Director, New York State Department of Health